ADDITIONAL TREATMENT PLAN

Confidential

State of California
Additional Treatment Plan
VCGCB-VOC-6025 (Rev. 03-15-04)

California Victim Compensation and Government Claims Board

Return Form To:

Victim Compensation Program
P.O. Box 3036
Sacramento, CA 95812-3036

Or Your Local Victim/Witness Assistance Center Verification Unit

Claim #	**Date Form Sent**
Victim's Name	
Claimant's Name	
Incident Date	

This form must be completed if your client has reached the mental health benefit service limitations and additional treatment is necessary as a direct result of the crime. Requests for additional treatment beyond the mental health service limitations will be reviewed with increasing rigor. Additional information, which may include session notes or objective assessments of impairment, may be needed to evaluate or verify this request for additional treatment. **If approved, this Additional Treatment Plan will authorize up to but no more than 25 sessions for direct victims and up to but no more than 15 sessions for derivative victims.**

Mental Health Benefit Service Limitations:

40 Sessions:	**30 Sessions:**	**15 Sessions:**
Direct Victim (Minor)	Direct Victim (Adult); or Direct Victim of Unlawful Sexual Intercourse [violation of PC §261.5 (d)]; or Derivative: Qualified Surviving Family Member of Homicide Victim or fiancé (fiancée) of homicide victim who witnessed the crime; or Derivative: Eligible Primary Caretaker (Shared)	Derivative (All Others Eligible for Mental Health Counseling)

Session Calculation:

Individual/Family: 1 Session Hour = 1 Session	Group: 1 Session Hour = .5 (1/2) Session

As required by law, the information requested by the Program must be returned to the Board **within ten (10) business days** and must be provided at no cost to the client, the Board, or local Victim/Witness Assistance Centers. The Victim Compensation Program certifies that there is a signed authorization on file for the release of the information requested.

Please answer questions fully and complete the signature page at the end of the document. Use additional pages if necessary. Failure to complete this form may result in a delay or denial of payment.

You must complete this form to request reimbursement, regardless of the extent of treatment given.
Complete all questions unless otherwise specified.

1. Name of Client	2. Name of Victim
3. Client's Relationship to Victim:	
4. Name of Therapist	5. Provider Organization Name
6. License/Registration Number and Expiration Date	

DATE COMPLETED_____

7. Mark Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)

☐ LMFT	☐ LMFT Intern
☐ LCSW	☐ ASW
☐ Licensed Clinical Psychologist	☐ Registered Psychologist
☐ Licensed Psychiatrist	☐ Resident in Psychiatry
☐ Psychological Assistant Intern	☐ Other (Please specify):

8. Name and Title of Supervising Therapist (If applicable)

9. License Number	10. Expiration Date

If you have previously completed a treatment plan, skip questions 11 and 12 and begin with question 13.

11. What is the victim or caregiver's initial description of the crime incident for which they are receiving treatment?

12. What are the client's presenting symptoms/issues (by your observation and client report)?

If this is the first treatment plan you have completed for this client, skip questions 13 and 14.

13. List the symptoms or other behaviors that have been a focus of your treatment.

14. Describe the major adverse effects these symptoms have had on the course of your client's life since the crime(s).

15. Please evaluate this client with respect to the DSM IV criteria. Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

16. **If this client is six years of age or older**, please evaluate him or her on the Social and Occupational Functioning Assessment Scale (SOFAS) that is discussed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM). (Note: Rate the relational unit in which he or she resided at the time of this report). Score:_____.

☐ Client is under 6 years of age.

Please describe your client's specific behaviors that support this rating:

17. Please evaluate the client on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM). (Note: Rate the relational unit in which this client resided at the time of this report). Score: _____.

Please provide the basis for this rating:

18. Is your client taking medications related to the mental health treatment?

☐ Yes
☐ No
If no, please explain why:

If you have previously answered this question on the Treatment Plan, skip this question.

19. If your client suffers from any physical and/or developmental disabilities, please note the nature and extent of each disability, any resources other than your treatment which the client may receive in connection with the disability, and show how the disability is reflected in your treatment plan.

☐ No disabilities

If this is the first treatment plan for this client, skip this question.

20. Please describe any factors not already noted which have had a significant effect on the course of your treatment of your client.

21. Please identify any of the following factors, which may interfere with treatment.

	No/Not Applicable	Yes
Mental status	☐	☐
Personal history	☐	☐
Support system	☐	☐
Justice system status	☐	☐
Family integrity	☐	☐
Economic/employment status	☐	☐
Other: _____	☐	☐

If you answered yes to any factors above, please explain.

22. Based on the information presently available, what is your prognosis for resolution of the concerns for which you were consulted?

23. TREATMENT PLAN

Please state your goals for treatment and describe how you hope to accomplish these goals.

Do not include goals that would be generic to any treatment plan (e.g., build rapport, increase self-esteem, etc.).

Goals	Methods/Management	Progress Measurement	Percentage Completed
1.			
2.			
3.			

DECLARATION

CLIENT NAME: _____ CLAIM NUMBER: _____

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for the victim. The treating therapist must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary to the percentage indicated below as a direct result of the crime.

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

☐ 0% ☐ 75%
☐ 25% ☐ 100%
☐ 50% ☐ Other %

B. What type of crime is the client being treated for?

Assault with a deadly weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery ☐ Hit and Run ☐

Driving Under the Influence ☐ Homicide ☐ Other (Do not include any confidential facts in your description of the crime.) ☐ _____

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling treatment must be approved in advance. Approval for reimbursement is limited to no more than 25 sessions for direct victims and 15 sessions for derivative victims. Treatment beyond that number of sessions will not be reimbursed until approved. I understand that if treatment is provided without the required approval, the Program may not reimburse those expenses.

IMPORTANT – Required signature(s) below MUST be provided

Treating Therapist:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

If Registered Intern:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____

Clear Form Print